INPATIENT GERIATRIC REHAB TRIAGE GUIDELINE*

Is patient a candidate for inpatient high tolerance or low tolerance rehab based on GTA Rehab Network Inpatient Rehab Referral Guidelines?

See page 2 for GTA Rehab Network Guidelines' criteria to determine if patient is:

- **a candidate for inpatient rehabilitation**
- **medically stable and**
- **rehab ready**

Yes

No

Monitor patient status and/or consider other discharge destinations.

Is **key reason** for rehab, patient's impaired premorbid functioning** **or** current multi-system needs?

No

Key reason for rehab is to address functional impairment arising from recent acute event (e.g. ABI, Stroke, MSK/FHRAT[i], etc.)

Is tolerance level*** ≥ **120 min.** daily x 5 days/wk?

Yes

No

Yes

Yes

Diagnosis-specific Dedicated/Mixed Rehab (e.g. ABI, Stroke, MSK/FHRAT[i] etc.)

Diagnosis-specific LTLD Rehab

Refer to **Dedicated Geriatric Assessment/Rehab Programs**[‡] **if** focus of rehab is:

1. Impaired premorbid functioning** **and/or**
2. Current multi-system needs.

Refer to **Geriatric Rehab on Mixed Units**[‡] or **LTLD Geriatric Rehab if** focus of rehab is:

1. Current multi-system issues **and/or**
2. *Mild* premorbid functional impairment**

Note: Referrals for patients ≤ 65 who have current multi-system needs and/or ***any*** level of impaired functional impairment can also be referred to the organizations listed below.

Tolerance*** criteria varies among these programs from high – moderate - low intensity	**High tolerance programs**: Tolerance*** ≥ 120 min. daily x 5 -7 days/wk)	**Low tolerance programs**: Tolerance*** =30 minutes, 2 sessions per day, 3x/week
▪ Baycrest ▪ Credit Valley Hospital (D) ▪ Lakeridge Health (D) ▪ Providence Healthcare ▪ Rouge Valley Health ▪ Toronto Rehab/University Centre (D, G Psy)	▪ Bridgepoint Health (D) ▪ Halton Healthcare Services (D) ▪ Markham Stouffville Hospital ▪ Rouge Valley Health System ▪ William Osler Health Centre ▪ York Central Hospital (D)	▪ Bridgepoint Health (D) ▪ Lakeridge Health (D) ▪ Rouge Valley Health System ▪ Toronto Grace ▪ Toronto Rehab/ Bickle Centre ▪ West Park Healthcare Centre (for patients ≥ 65 years of age)

Legend: Specialized Services
Dialysis (D) Geriatric Psychiatry (G Psy)
Note: Organizations listed are those that accept external referrals.

[i] Fractured Hip Rapid Assessment and Treatment model of care

* Triage Guidelines are also applicable to medically complex patients ≤ 65 years of age.

** See Pre-Morbid Function Screen on page 16.

***Tolerance denotes participation in all activities scheduled with therapy and nursing staff.

[‡] For a brief description regarding these types of programs, please see page 4. A listing of program descriptions for each category can be found in Appendix F of the GTA Rehab Network's report, *Clarifying the Complexities of Inpatient Geriatric Rehab*, February 2007.

Inpatient Rehab Referral Guidelines
Criteria for Rehab Candidacy, Medical Stability and Rehab Readiness

(Please see the complete Inpatient Rehab Referral Guidelines document (www.gtarehabnetwork.ca) for guidelines regarding Timing and Submission of Referrals and Response to Referrals)

Determining if a patient is a <u>candidate</u> for inpatient rehabilitation …

- ✓ Patient demonstrates by documented progress the potential to return to premorbid/baseline functioning or to increase in functional level with participation in rehab program.
- ✓ There is reason to believe that, based on clinical expertise and evidence in the literature, the patient's condition is likely to benefit from the rehab program/service.
- ✓ Goals for rehabilitation have been established and are specific, measurable, realistic and timely.
- ✓ The patient or substitute decision-maker has consented to treatment in the program and demonstrates willingness and motivation to participate in rehab program.

  (Exception: patients with reduced motivation/initiation secondary to diagnosis e.g. brain injury, depression).

Determining <u>Medical Stability</u> …

- ✓ A clear diagnosis and co-morbidities have been established.
- ✓ At the time of discharge from acute care, acute medical issues have been addressed; disease processes and/or impairments are not precluding participation in rehab program.
- ✓ Patient's vital signs are stable.
- ✓ No undetermined medical issues (e.g. excessive shortness of breath, falls, congestive heart failure).
- ✓ Medication needs have been determined.

Determining <u>Rehab Readiness</u> …

- ✓ Patient meets the criteria of a rehab candidate and medical stability as defined in guideline above.
- ✓ All medical investigations have been completed ***or*** a follow-up plan is in place at time of referral and follow-up appointments made by time of discharge.
- ✓ Patient's special needs have been determined.
- ✓ Patient is able to meet the minimum tolerance level of rehab program as defined by the admission criteria of rehab program.
- ✓ There are no behavioural or active psychiatric issues limiting patient's ability to participate in rehab program.
- ✓ Treatment for other co-morbid illnesses/conditions does not interfere with patient's ability to participate in rehab (e.g. dialysis or active cancer treatment resulting in fatigue or frequent absences from unit during rehab treatment sessions).
- ✓ Patient's discharge options following rehab have been discussed.

Premorbid Function Screen*

1. **Nutrition**
   Has patient had unanticipated weight loss in the last year (i.e. clothes fit loosely or weight loss ≥ 5% of body weight)? **Yes↑** **No↑**
2. **General Health Status**
   Has patient had two or more admissions to hospital in the last year? **Yes↑** **No↑**
3. **Medication use**
   Did patient use 5 or more prescription medications on a regular basis? **Yes↑** **No↑**
4. **Functional Independence**
   Did patient need help with 3 or more of the following: (meal preparation, shopping, transportation, telephone, housekeeping, laundry, managing money, taking medications)? **Yes↑** **No↑**
5. **Continence**
   Did patient have a problem with losing control of his/her urine? **Yes↑** **No↑**
6. **Mobility**
   Has patient had a fall in past year? **Yes↑** **No↑**

Score = Total # of Yes answers. _____

Rating key: Mild Pre-morbid Challenges (1-2); Moderate Pre-Morbid Challenges (3-4); Severe (5-6)

* Screening tool is derived from the Edmonton Frail Scale (EFS) (see below). The following items used in the EFS were not included: Cognition, Social Support, Mood and Functional Performance. However these areas are addressed in the Inpatient Rehab Referral Guidelines of the GTA Rehab Network. The rating key is not part of the published tool.

References:

Bergman H, Beland F, Karunananthan S et al. Development of a framework for understanding and studying frailty. Gerontologie et Societe 2004:109:15-29.

Fried LP, Tangen CM, Walson J, et al. Frailty in older adults: evidence for a phenotype. J. Gerontology A Biol Sci Med Sci2002:57A(3):M146-M156.

Naglie G, Gill SS. A systematic review of risk factors for functional disability in older adults. Toronto Rehabilitation Institute, University Health Network, University of Toronto, Toronto, Ont. and Queen's University, Kingston, Ont. Abstract.

Rockwood K, Hogan DB, MacKnight C. Conceptualization and measurement of frailty in elderly people. Drugs Aging 2000; 17:295-302.

Rolfson D.,Majumdar, Tsuyuki R, Tahir A, Rockwood K. Validity and reliability of the Edmonton Frail Scale. doi:10.1093/aging/afl041. Published electronically 6 June 2006.

Glossary of Definitions for Geriatric Rehabilitation[1]

Geriatric Rehabilitation

A program designed to optimize the functioning of the elderly and often pre-morbidly frail individual who has experienced a loss of independence due to acute illness or injury. This is often superimposed on chronic functional and medical problems. Geriatric rehabilitation provides evaluative, diagnostic and therapeutic interventions to restore functional ability or enhance residual functional capacity in elderly people with disabling impairments.[2]

Dedicated Geriatric Assessment/Rehab: Also known as Geriatric Rehab Units (GRU), Geriatric Assessment and Treatment Units (GATU) and Geriatric Assessment and Rehab Units (GARU)

- These programs provide a moderately intensive rehab program provided by an interdisciplinary rehab team with expertise in geriatric assessment and treatment.

- Rehabilitation includes assessment and treatment of geriatric syndromes that include:
  - Instability or falls
  - Cognitive impairment including delirium and dementia
  - Immobility
  - Inadequate nutrition
  - Isolation or depression
  - Incontinence
  - Poly-pharmacy

- The key differentiating feature of geriatric rehab is that the assessment and treatment of these multi-dimensional factors are as much a part of the rehab focus as is the illness or injury which directly led to the most recent hospitalization. On geriatric rehab units, the emphasis is on restoration of functional status.

- Core team typically includes: Physician, Nursing, Physiotherapy, Occupational Therapy, Social Work, Pharmacy, Speech-Language Pathology, Clinical Dietician, Therapeutic Recreation and Chaplaincy/Pastoral Care.

- Geriatric rehab treats patients who are typically frail, have multiple co-morbidities and functional impairment with complex underlying medical and functional problems, unexplained pre-morbid problems coping at home and/or an insult or complicated course in hospital such as delirium, pneumonia or a fracture.

- It is expected that geriatric rehab patients can tolerate a minimum of 60 minutes of therapeutic activity, although an average of 120 minutes of therapy per patient, 5- 7 days per week is offered. Therapeutic activity includes professional therapy (e.g. OT, PT and/or SLP) *and* nursing activities.

- Typical length of stay based on the Toronto Regional Geriatric Program guidelines for GATUs/GARUs is 4-6 weeks and 4-12 weeks for GRU.

- This type of rehab may be located in designated rehab beds or complex continuing care beds.

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[1] These definitions have been developed as part of the GTA Rehab Network's Definitions initiative. Please see the GTA Rehab Network's report, *Clarifying the Complexities of Geriatric Rehab*, (February 2007) for full details.

[2] Wells JL, Seabrook JA, Stolee P, Borrie MJ, Knoefel F. State of the art in geriatric rehabilitation. Part 1 Review of frailty and comprehensive geriatric assessment, Arch Phys Med Rehabil 2003:84:890-7.

Geriatric Rehab on Mixed Units: Also known as General or Medical Rehab

- Rehab providers assess/treat a variety of diagnostic/rehab population groups; however, specialization in multi-system issues and familiarity with the principles of geriatric care from at least the medical staff is strongly encouraged where there is a sufficient critical mass of geriatric patients (i.e. a minimum of 8 beds) to support the development and maintenance of such clinical expertise.

- Geriatric patients who are appropriate for a mixed unit are patients whose primary diagnosis falls outside of the other rehab population groupings (e.g. MSK, Stroke) and who have current multi-system issues and/or whose premorbid functioning was no more than mildly compromised as assessed by the Premorbid Function Screen (see page 3.

- These programs provide an intensive rehab program by an interdisciplinary rehab team. Core team includes: Physician, Nursing, Physiotherapy, Occupational Therapy, Social Work, Pharmacy, Speech-Language Pathology, Clinical Dietician, Therapeutic Recreation and Chaplaincy/Pastoral Care.

- Average amount of therapy provided per patient is 120 minutes daily for 5-7 days as tolerated by the patient. Tolerance includes participation in all activities scheduled with therapy and nursing staff.

- Typical length of stay is 2-8 weeks.

- This type of rehab is typically located in designated rehab beds in community hospitals.

LTLD Geriatric Rehab: Also known as Geriatric Activation or Functional Enhancement.

- These programs provide a low to moderately intensive rehab program for patients who have experienced a complicated course in hospital or a recent multi-system illness requiring a longer period of rehabilitation of lower intensity than that offered in mixed rehab units. The Program is appropriate for patients whose pre-morbid functioning may have been impaired but whose primary rehab need is to address current multi-system needs through a slower-paced, longer duration rehab program.

- Core team includes: Physician, Nursing, Physiotherapy, Occupational Therapy, Social Work, Pharmacy Consultation, Speech-Language Pathology, Clinical Dietician, Therapeutic Recreation and Chaplaincy/Pastoral Care.

- Average amount of therapy provided per patient is on average 30 minutes, 2 sessions per day, 3 times per week as tolerated by the patient. Tolerance includes participation in all activities scheduled with therapy and nursing staff.

- For programs that specifically identify themselves as providing LTLD Geriatric rehab, specialization is encouraged to support the development and maintenance of clinical expertise in geriatrics and multi-system issues at least in the medical staff.

- Typical length of stay is 3 – 6 months.
- LTLD Geriatric Rehab is typically located in complex continuing care beds.